TCM Rate Setting

1. Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. Section 1902(a)(4) of the Act specifies that the State plan must provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of the plan.

   In evaluating a State's TCM rate, CMS asks the state to identify the payment per unit. (Note that CMS does not recognize daily, weekly or monthly rates as being an economical method for reimbursing for non-institutional services.) For example, a state has proposed a fee schedule reimbursement of approximately $**16** for each 15 minute unit of service. Annualized in the following manner--$**16** per fifteen minute unit X 4 units per hour X 2080 working hours in a year, the rate results in approximately $**133,120** of reimbursement. This raises concerns that, on the face of it, this annualized amount appears to exceed the reasonable cost of providing targeted case management.

   In developing an economic and efficient rate for TCM services, CMS currently recognizes the following types of cost:

   (1) Salary cost of direct practitioners by type of practitioner (not supervisors or support staff) by FTE adjusted for other sources of funding such as Federal and State grants.

   (2) Some fringe benefits such as employer cost of health insurance, Medicare and Social Security contributions. The State must show the actual cost for each type of benefit proposed for inclusion in the rate.

   (3) Indirect costs – CMS has accepted an indirect cost component of 10%.

   (4) A reallocation of general and administrative costs ("non-productive time") is permissible only if the State has used a CMS-approved, statistically valid time study to identify the percentage of time spent performing these activities. If no time study is available, the State must provide specific documentation (e.g. State statute specifying number of required training hours, paid state holidays, etc) to justify the amount of such "non-productive time" to be reallocated.

   (5) The State may include the actual cost of transportation when developing the rate. However, those components used (i.e. mileage and mileage rate) must be based on actual amounts.

(6) The State must assure that billed time does not exceed available productive time by practitioner to deliver the targeted case management services and must specifically identify billing limits in the SPA.

CMS requires the State to justify its payment based on cost incurred to provide the service. For each of the cost components recognized as eligible for reimbursement, please provide complete data to support the proposed payment.

2. What are the sources of funds used for the payment of targeted case management services? Reimbursement for Medicaid services provided by governmental providers is dependent upon the manner in which a state funds the non-Federal share of those services. Specifically:

   If certified public expenditures (CPE) are the source of funds, the State Plan must provide for reimbursement to the governmental provider at cost. In addition, the provider must have a cost-accounting system in place to appropriately identify, out of the total pool of costs incurred in providing services to all of its clients, only those that represent expenditures made on behalf of Medicaid beneficiaries for targeted case management services. The process would involve use of a statistically valid time study to identify the time spent providing medical services, costs would have to be allocated to Medicaid and the state would have to delineate in its plan the specific direct and indirect costs the provider would certify and how they are used to develop the rate. The interim payments made during the year must be annually reconciled to actual Medicaid cost at the level of the provider certifying the expenditures. The certification of expenditures would be based on this year's (or last year's) costs (salaries, fringes, etc., as allocated using last year's time study). Reconciliation at the end of the year would compare Medicaid costs for this year allocated according to this year's time study.